CHANGE: EMOTION, BODY AND RELATEDNESS

[L'EMOZIONE, IL CORPO E IL SENSO DE VICINANZA]

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"*There is a distinct physical sensation of change, which you recognize once you experienced it. We call it a body shift. When people have this even once, they no longer helplessly wonder for years whether they are changing or not. Now they can be their own judges of that*" (Gendlin, 1981, p. 7)

A model of therapy needs at its essence to be a model of change. My goal here is to begin to articulate the metapsychology of therapeutics. This metapsychology of the therapeutic process should not be derivative --a poor cousin-- of the theory of psychopathology, but function as a strong explanatory framework in its own right. That this question arises is an homage to the transformational power of the experiential STDPs: it is the deep and rapid transformations that can be observed in the wake of the affective breakthroughs of the experiential STDPs that push us to develop a model that can explicate the phenomenology and dynamics of change.

In order to elaborate a comprehensive model of therapeutic change, I will describe affective change processes that involve emotion, relatedness and the body (Fosha, 2001b). The study of these areas has been shaped and informed by clinical experiences with therapeutic methods which produce rapid and dramatic change. The defining phenomenology and dynamics of change that we are seeking to explicate are the deep and rapid transformations that can be observed

in the wake of the affective breakthroughs of the experiential STDPs (Alpert, 1992; Coughlin Della Selva, 1996; Davanloo, 1990; Fosha, 2000; Kalpin, 1994; Magnavita, 1997; Malan, 1976; Malan & Osimo, 1992; McCullough Vaillant, 1997; Osimo, 1998; Sklar, 1994), as well as other emotion-focused experiential psychotherapies (Gendlin, 1981; Greenberg & Paivio, 1997; Greenberg, Rice & Elliott, 1993; Levine, 1997; Perls, 1969).

The key mutative agent of the experiential STDPs is considered to be the facilitation of (i) the *visceral experience* of (ii) *core affective phenomena* in the context of (iii) an *emotionally-engaged therapeutic relationship* (Fosha, 2000). Thus, a psychodynamic conceptual framework has to account for the transformational power of the three basic constituents of change in the experiential STDPs: core emotion, dyadic relatedness and access to the body and visceral experience.

Traditional psychoanalytic theory has been unequaled in the depth of understanding it provides into the phenomena, processes and mechanisms by which psychopathology develops and is maintained. However, the depth of understanding of pathology has not been matched by a depth of understanding of the phenomena of healing. The psychoanalytic metapsychology of therapeutic change, such as it is, as well as the psychoanalytic theory of optimal development for that matter, remain wedded to processes of pathology. This tendency finds most blatant expression in the Kleinian tradition where generic stages of normal development are given clinical names, i.e., the *schizoid* and

depressive positions, and where the depressive position is seen as being as good as it gets. Not surprisingly, a model of change rooted in pathology is better at explaining how and why people don't change (or get worse), than it is at explaining how and why people get better.

In contradistinction, AEDP's understanding of how therapy works derives from an examination of different areas where transformation operates powerfully, often rapidly and dramatically. Fundamentally, AEDP is a psychodynamic model; however, the inspiration for precisely those aspects which distinguish it from other psychodynamic approaches (both short- and long-term) comes from the rootedness of AEDP in natural change processes, and their characteristic phenomena.

[*N.B*. While it is my belief that the model of change I am articulating is applicable to all the experiential STDPs, in fact, it is only AEDP (Accelerated Experiential Dynamic Psychotherapy; Fosha, 2000; Fosha & Slowiaczek, 1997) which is explicitly informed by it. Many of the other approaches still use a more traditional psychodynamic framework, which to my mind, does not do justice to the defining phenomena of the therapy. For the sake of accuracy and so as not be presumptuous, for the remainder of this article, I will refer to AEDP specifically, rather than to the experiential STDPs collectively.]

Several bodies of theory and research have proved useful in helping restructure traditional psychodynamics into an affect-centered model that can

account for the therapeutic phenomena that emerge upon the application of the techniques of the experiential STDPs.

- Emotion theory and affective neuroscience offer an account of change intrinsic to the experience of the *categorical emotions* (Damasio, 1994, 1999; Darwin,1872; James, 1890; Lazarus, 1991; LeDoux, 1996; Siegel, 1999; Tomkins, 1962, 1963), universal phenomena characterized by specific neurophysiological and body signatures, and by the state transformations and adaptive action tendencies released upon their experience and expression;
- Attachment theory and the work of clinical developmentalists on moment-to-moment mother-infant interaction document how optimal development and life-long resilient functioning have their roots in child-caregiver dyadic processes, highlighting the processes by which infants and caregivers mutually regulate moment-to-moment affective states (Beebe & Lachmann, 1988, 1994; Emde, 1981, 1988; Stern, 1985; Schore, 1994; Trevarthen, 1993; Tronick, 1989, 1998) and achieve safety and resonance despite the vicissitudes of attachment, self states and relatedness (Ainsworth et al, 1978; Bowlby, 1982, 1988; Fonagy, et al., 1991, 1994; Main, 1995, 1999);
- The somatic focusing experiential tradition has documented how the psyche is transformed through the simple shifting of focus away from in-the-head cognition and toward moment-to-moment in-the-body sensing and feeling, a process which restores access to natural healing processes rooted in the body's

basic adaptive mechanism (Gendlin, 1981, 1991; Kurtz, 1990; Levine, 1997; Pesso & Boyden, 2000).

These fields thus offer ample empirical evidence of the mechanisms through which naturally-occurring affective phenomena involving emotion, relatedness and the body lead to rapid, deep and long-lasting change. These changes processes (1) operate moment-to-moment; (2) are affective in nature and have clear-cut affective markers; (3) operate through transformations of state, in which the new state (the *core state*, see Fosha, *in press*) is characterized by greater access to emotional resources, higher adaptive functioning, and is marked by positive affects; and (4) operate in quantum leaps, rather than in a gradual and cumulative fashion.

In AEDP, we seek to harness the power of these natural change processes to effect therapeutic results. When defensiveness, fear and shame have been neutralized and cleared away, we gain access to the processes of change. They all share a two stage process, involving two state transformations: When interventions aimed to counteract defenses, anxiety and shame are effective, there is a breakthrough of core affect. The full visceral experience of a specific core affective phenomenon constitutes the first state transformation. In turn, the full experience of core affect, unhampered by defense, culminates in the activation of yet another state, the *core state*, in which therapeutic work is at its most effective. In the core state, relaxation, vitality, ease, clarity and well-being

predominate. Core state affective markers are invariably positive. The shift from core affect to core state represents the second state transformation.

A direct consequence of the focus on change and the study of change processes is the appreciation of the crucial role of positive emotional experiences in therapy, an area of experience often neglected or only minimally discussed. Since much of what has to be renegotiated in the course of treatment are difficult, painful experiences, at times of unbearable proportions, therapy is commonly assumed to of necessity focus on the bad stuff; positive affective experiences are seen as the outcome of therapy, but not inherent in and integral to the processes of therapy. While there is no denying that the in-depth exploration of painful overwhelming matters is often excruciating, the study of the features of processes of change has alerted us to previously ignored or misinterpreted phenomena: : positive affective experiences are part and parcel of the *moment-to-moment process* of transforming the suffering associated with pathological conditions. Positive affects are the invariant markers of core state.

The three affective change processes involving emotion, dyadic relatedness and the body represent different *paths to the high adaptive functioning and subjective well being characteristic of the core state*, i.e., different paths to bypassing defenses, alleviating the impact of pathogenic inhibiting affects like fear and shame, and maximizing the experience and expression of core affective experiences. Each pathway, however, as we will

now see, has its own characteristic core affective phenomena, its own path of therapeutic action and therapeutic benefits specific to it.

L'EMOZIONE (EMOTION) - The First Change Process

Emotion theory (Darwin,1872; James, 1890; Lazarus, 1991; Tomkins, 1962, 1963) and now affective neuroscience (Damasio, 1994, 1999; LeDoux, 1996; Siegel, 1999), teach us that emotions are crucial vehicles for adaptation. Being aware of, in touch with, and able to express emotions help individuals access biologically adaptive information that can assist them in negotiating life (Greenberg & Safran, 1987). As "central aspects of biological regulation, [emotions] provide the bridge between rational and non-rational processes, between cortical and subcortical structures" (Damasio, 1994, p. 128). They convey information about the individual's appraisal of the environment, focus attention on what is most important to her/him, and thus motivate actions (in self) and responses (in others). Affects mediate the interaction between the individual and her/his emotional environment; they are sources of information and personal meaning, and underlie experiences of authenticity and liveliness. However, the most essential information that emotions convey is information about the self in relation to and with others.

Categorical, or core, emotions include fear, anger, sadness, joy, or disgust. They are the big universal emotions. They are not small and they are not idiosyncratic. They are deep-rooted bodily responses with their own specific

physiology and arousal pattern (Ekman, 1983; Zajonc, 1985). All core affective phenomena, each categorical emotion is characterized by a "*distinctive biological signature*" (Goleman, 1995, p. 6). Anger or rage, for instance, goes with the physiological profile preparing one for fight or flight; "[b]lood flows to the hands, making it easier to grasp a weapon or strike at a foe; heart rate increases, and a rush of hormones such as adrenaline generates a pulse of energy strong enough for vigorous action" (Goleman, 1995, p. 6). The categorical emotions

> "are said to express universal biological rules handed down genetically through evolution because they have proved adaptationally useful. They arise from an inherited neural structure, involve a characteristic neuromuscular response pattern, and are correlated with distinctive subjective qualities for each emotion. . . The face, through a complex and interconnected set of muscles, gives innate expression to the primary emotions that humans inherited in the evolution of the species, and . . . the pattern of expression for each emotion is universal for that species. In humans, there is, in effect, an anger face, a fear face, a happiness face, and so on, although to some extent sociocultural variables can affect the pattern and timing of expression, and an emotional face can be inhibited, disguised or produced for effect" (Lazarus, 1991, pp. 70–71).

Note the reference to defensive processes in Lazarus's account.

The full visceral experience of core emotion in the absence of defenses and anxiety or shame, ushers in a state transformation where there is visceral access to precisely that which defenses had previously rendered off limits, that is, (1)

previously unconscious material and (2) previously unavailable emotional resources. Core emotion can be regarded as the royal road to the unconscious, unlocking unconscious and previously inaccessible feelings, thoughts, memories, fantasies related to the very roots of the patient's pathology. Core affective experience is crucial to the actualization of the core psychoanalytic agenda of uncovering the unconscious, i.e., it gives us --patient and therapist-- direct access to the raw materials required for a thorough working through.

In addition, the patient's full absorption in a highly precise and specific experience of a particular core emotion ushers in the core state, where the *adaptive action tendencies*, an emotion theory term I have adopted, associated with each emotion are released. A key defining aspect of the experience of each categorical emotion includes a specific tendency toward some expressive action: "each emotion offers a distinctive readiness to act; each points us in a direction that has worked well to handle the recurrent challenges of human life" (Goleman, 1995, p. 4). In emotion theory, the new capacities accessed by the visceral experience of core emotion are called *adaptive action tendencies*.

> "Specific emotional states are thus linked with specific action dispositions. Anger, for example, occurs in response to an event experienced as an assault and is associated with actions which are self-protective and retaliative. Fear is evoked by events appraised as dangerous and is linked to hypervigilance and flight. Love is linked to affiliative behaviors. The core of emotional experience thus consists of organized expressive-motor

acts associated with behavioral systems that are biologically wired-in through a process of natural selection" (Safran & Segal, 1990, p. 57).

The adaptive action tendencies released by the visceral experience of categorical emotion give the individual access to new resources, renewed energy and an adaptive repertoire of behaviors, thus enhancing her/his functioning. The individual's new responses reflect her/his access to new emotional information—about the self, the other, and the situation—that was not accessible to her/him prior to the full experience of the emotion

Even when the categorical emotion is itself negative and/or painful, as in the case of anger or grief, the core state to which follows the release of the adaptive action tendencies is experientially highly positive. For instance, the adaptive action tendencies released by fully experienced anger often include a sense of empowerment and an assertiveness rooted in the rediscovery of psychic strength, self-worth, and affective competence. Jean Genet says: "“Acts must be carried through to their completion. Whatever their point of departure, the end will be beautiful. It is (only) because an action has not been completed that it is vile” (quoted in Levine, 1997, p. 33). The full, visceral experience of core emotion leads to access to positive experiences of strength, clarity, acceptance, vitality or calm. And these feel good.

IL SENSO DE VICINANZA (RELATEDNESS): The Second Change Process

As with emotion, adaptation is a central concept in understanding the function of the dyadic relational experience and its crucial role in affective regulation, our second source of transformation. The literature on attachment (Ainsworth et al., 1978; Bowlby, 1982, 1988; Lyons-Ruth, 2001; Main, 1995) roots the importance of the child-caregiver bond in its capacity to provide protection from danger; psychically, the attachment bond promotes emotional survival through protection against psychic danger (anxiety), engendering in the child a sense of safety. Secure attachment promotes resilience and reduced vulnerability to the development of psychopathology (Fonagy et al., 1994) and has been shown to be functionally synonymous with optimal emotional development, and better functioning at all developmental levels (Fonagy et al., 1991; Main, 1995).

Secure attachment describes a relationship within which the child's emotional experiences --be they moment-to-moment micro fluctuations in vitality affects (Stern 1985; Trevarthen, 1993), or the macro-affects associated with the vicissitudes of attachment-- are met by the caregiver's openness, responsiveness and willingness to help. Optimally adapted individuals emerge from dyads in which affects do not disrupt the basic relational bond; quite the opposite, they deepen and enhance it (Cassidy, 1994). Most importantly, in such dyads, the inevitable disruptions in mutuality are short-lasting, and become powerful motivators of reparative efforts. What emerges out of this process is *affective*

competence, i.e., emotional security, trust, self-confidence, and the capacity to deal with emotional experience (see also Fosha, 2000, chap. 2 & 3).

Security of attachment promotes an expanded range of exploration. The safer children feel, the wider the range of their explorations: when they can count on the caregiver as a safe base, children can play (see also Winnicott, 1974). For it is through the exploratory aspects of attachment that growth and learning takes place, and thus optimal adaptation is served (Ainsworth et al., 1978). Here too, we have positive affective markers: First, the safety feeling, which is not solely the absence of fear and anxiety, but involves the actual experience of well-being (Sandler, 1960). Secondly, the affects accompanying the exploratory behavioral system, i.e., excitement, curiosity and exuberance, are positive and highly pleasurable experiences. Applying the safety/exploration equation to treatment, the safer patients feel in the dyadic relationship with the therapist --a dyad devoted to affect regulation-- the more they will be willing to take risks and explore the previously daunting inner world of their emotional experience.

The power of relatedness as a powerful change process accompanied by positive affective markers is also documented in the moment-to-moment caregiver-infant interaction literature (Beebe & Lachmann, 1988,1994; Gianino & Tronick, 1989; Stern, 1985; Trevarthen, 1993; Tronick, 1988, 1998). The dyadic relatedness involved in maintaining the flow of emotional communication involves a moment-to-moment psychobiological process of *attunement* (i.e., mutual coordination of affective states), *disruption* (i.e., a lapse

of mutual coordination) and *repai*r, leading to the restoration of attunement (i.e., the reestablishment of mutual coordination). What emerges out of this process of attunement, disruption and repair is *affective competence*, i.e., emotional security, trust, self-confidence, and a sense of the self as effective in its capacity to regulate stress-producing emotional ups and downs.

Each phase has its own characteristic markers. While negative affects accompany the stress-producing disruption of mutual coordination and attunement, positive affects accompany 'in sync' experiences, i.e., “peak experiences of resonance, exhilaration, awe and being on the same wavelength with the partner” (Beebe & Lachmann, 1994, p. 157). The achievement and/or restoration of coordination engenders a state transformation: it is marked by positive affects which are pleasurable to *both* members of the dyad. This is true even of the coordination the dyad needs to reach around negative affects. Whether the dyad is regulating joy, excitement, exuberance and playfulness or distress, anger, fear or frustration, 'getting in sync' is always accompanied by shared positive relational affect.

Optimally functioning dyads, i.e., those that give rise to securely attached and thus resilient children, are not characterized by longer periods of uninterrupted attunement. The rise and fall of coordination is a natural process. Rather, these optimally functioning dyads are characterized by the effectiveness of their reparative efforts: they are excellent at collaboratively metabolizing the negative affects associated with the disruption of coordination and regaining mutual

coordination and the positive affects that accompany it (Tronick, 1989, 1998). Note that it is not only negative affective experiences which need to be regulated; intense positive affective experiences can also be overwhelming and in need of the stress-regulating activities of the dyad.

The maintenance of positive affective states associated with dyadic experiences of affective resonance has been shown to be crucial to optimal neurobiological development. "The baby's brain is not only affected by these interactions, its growth literally requires brain-brain interactions and occurs in the context of a positive relationship between mother and infant" (Schore, 1996, p. 62; see also Trevarthen & Aitken, 1994).

These positive affects create a neurochemical environment highly conducive to new learning in which optimal brain development occurs: "The mother's face is triggering high levels of endogenous opiates in the child's growing brain. These endorphins … act directly on subcortical reward centers of the infant's brain" (Schore, 1996, p. 63). Endorphins (endogenous opiates) trigger "an elevation of dopaminergic-driven, energy-mobilizing, sympathetic-dominant ergotropic arousal and dopamine-mediated elation" (Schore, 1996, p.63), i.e., an energy-mobilizing state in which maximal learning takes place. The child is motivated to enter into such a "reciprocal reward system" because "euphoric states are perhaps the most appetitively compelling experiences available to life forms as so far evolved" (Schwartz, 1990, p. 125, quoted in Schore, 1996, p. 62). Euphoria has been here coopted to serve the organism's adaptive aims.

Dyadic experiences of psychobiologically attuned, affectively resonant interactions with primary caregivers, in the first year of life largely negotiated through gaze and voice transactions, are thus the best ways to foster brain development: these mutual transactions do not only regulate the positive affect in which optimal brain development takes place, but they themselves produce it. Infant research now suggests that the baby becomes attached to the affect-facilitating caregiver who expands opportunities for positive affect and minimizes negative affect (Demos & Kaplan, 1986). It is precisely that kind of interaction which leads to the dyadic expansion of consciousness (Tronick, 1998) and the maximal brain development mediating optimal adaptation.

> "Affect-transmitting, attention-focusing, social referencing experiences are mediated by a fast-acting dyadic visuoaffective psychobiological mechanisms and this interactive dynamic that generates and maintains high levels of the positive affects of elation and excitement allows for the appearance of an ontogenetic adaptation, play behavior. Play transforms an environment into one that facilitates the processing of novel information and thereby improves learning capacity. These incipient experiences of separations and reconnections that support play enable the child to be exposed to an "enriched" (ref) environment, one that shapes developing brain networks (refs) and increases neural interconnectivity" (Schore, 1996, p. 65-66).

Conversely, the stress associated with states of misattunement and the negative affects they engender creates a neurochemical environment marked by

inhibition, withdrawal and low energy. In such a stress-dominated state, there are few or no resources to be devoted to expansive exploration. The individual's capacity to learn and grow is not only *not* enhanced, it is significantly compromised:

> "This intense psychophysiological distress state, phenomenologically experienced as a "spiraling downward" is proposed to reflect a sudden shift from energy mobilizing sympathetic- to energy-conserving parasympathetic-dominant autonomic nervous system activity, a rapid transition from a hyperaroused to a hypoaroused state, a sudden switch from ergotropic high arousal to trophotropic low arousal…. This represents a shift into a low-keyed inhibitory state of parasympathetic conservation-withdrawal (Powles, 1992) that occurs in helpless and hopeless stressful situations in which the individual becomes inhibited and strives to avoid attention in order to become "unseen." This state .. reflects the reduced activation of the excitatory dopaminergic [system] and increased activation of the inhibitory noradrenergic [circuit]." (Schore, 1996, p. 69-70).

Chronic states of misattunement with prolonged states of unmetabolized negative affect, lead to a highly problematic psychophysiology: high levels of corticosteroids, which have been shown to be related to high unrelieved stress, play a major role in the psychobiology of posttraumatic stress disorder (van der Kolk, 1996). Chronic involvement in such states leads to actual dendritic shrinking and atrophy of certain regions of the brain (Schore, 2001; Siegel, 1999). In infancy, aversive dyadic interactions actually have been shown to lead

to neuronal cell death in "affective centers" in the limbic system as a result of the high corticosteroid levels generated, as well as to lead to alterations in opiate, dopamine, noradrenaline, and serotonin receptors. (Lyons-Ruth, 2001; Schore, 2001; Siegel, 1999; van der Kolk, 1996).

Thus optimal attunement and the positive affects accompanying metabolized affective experience produce optimal brain growth, whereas chronic misattunement and unmetabolized negative affect damage the brain. Allan Schore and Colwyn Trevarthen take the argument one step further: They argue that the central adaptive function of the attachment system *is* the maintenance of positive affect, which is needed for optimal brain development (Schore, 1996; Trevarthen, 1993; Trevarthen & Aitken, 1994). They argue that the maintenance of positive affect states is both *how* security of attachment is established and *why* the attachment system has been evolutionarily selected.

Thus, the dyadic regulation of both ordinary intense affective experiences produces the changes that are the stuff of optimal development. This has uncannily precise parallels in treatment (Fosha, 2001a). Research shows that the therapist's attunement to the patient's affective state and the patient's experience of feeling safe and understood, i.e., affectively resonated with, is probably the most powerful contributor to the achievement of positive therapeutic outcome (see also Rogers, 1957; Rosenzweig, 1936; Truax & Carkhuff, 1967).

IL CORPO (THE BODY) - The Third Change Process

The last change process I will examine is that which involves experiences rooted in the body. Just like theories of attachment, emotion and dyadic regulation, somatic focusing theory zooms in on adaptation and the organism's adaptive potential to self-regulate and self-heal, what is referred to in the vernacular as the wisdom of the body. "*The sense of what is wrong carries with it, inseparably, a sense of the direction toward what is right*" (Gendlin, 1981, p. 76).). Aeons of evolution have built into the body the capacity to right itself.

As with processes of core emotion and core relatedness, natural bodily reactions to traumatic and overwhelming events contain the seeds of healing within them. Intrinsic to these processes are self-righting, self-reparative tendencies (see also Emde (1981) on self-reparative tendencies, and Winnicott (1960) on the dogged search of the true self for conditions right for its emergence). In a powerful argument, Levine (1997) maintains that external events are never traumatic. What is traumatic is the interruption and interference with the body's natural healing mechanisms for psychophysiologically regulating the impact of intense external events.

When facing life problems that are beyond the individual's coping capacity at that moment (Gendlin, 1981) or when natural somatic processes are disrupted and interrupted by highly socialized cerebral machinations (Levine, 1997), tension and stress accumulate; the body is taken out of its naturally adaptive state. Instead of energy going into flow and problem resolution (at a visceral somatosensory level), energy goes into containing and keeping in, i.e., into

constriction and stress. Inhibition and withdrawal, rather than expansiveness and flow, predominate (cf. Schore's (1996) distinction between energy-mobilizing, sympathetic ANS activity involving the activation of the dopaminergic system vs. energy-conserving, parasympathetic ANS activity involving the inhibitory noradrenergic system). Thus, physical barriers get created in the body (i.e., the somatic equivalent of defense) and energy goes into maintaining them rather than dealing directly with the matters at hand.

The evolutionary development of, and human beings' increasing reliance on, the neocortex has led to the cortical overriding of more instinctual mechanisms in situations requiring reactions and skills that the cerebral cortex is not optimally suited to handle (LeDoux, 1996). Somatic experiencing aims to change the focus from intellectual and cognitive processes, and their experientially alienating consequences, by fostering a process of moment-to-moment tracking of the body's shifting experiences.

Experiential clinicians, Eugene Gendlin and Peter Levine most notably, have documented the phenomenological shifts that occur when the focus shifts from in-the-head cognition to in-the-body sensing. The process of somatic focusing can be conceptualized as a somatic/experiential method to get past defenses (the constricted, restricted, blocked state of stuckness and tension), so as to restore access to core phenomena which occur in a body state of relaxation and flow. Changes that involve shifting focus from head (read cognitive, intellectual, verbally dominated) to body (read somatic, sensory, visual) also lead to deep

experiential results. Key to the somatic focusing process is the *felt sense*, "the experience of being in a living body that understands the nuances of its environment by way of its responses to that environment" (Levine, 1997, p.69). The process of somatic focusing can be conceptualized as a somatic/experiential method to get past defenses (the constricted, restricted, blocked state of stuckness and tension), so as to restore access to core phenomena which occur in a body state of relaxation and flow. Changes that involve shifting focus from head (read cognitive, intellectual, verbally dominated) to body (read somatic, sensory, visual) also lead to deep experiential results.

The process of somatic focusing --where there is an oscillation between experience and reflection, each feeding on the other-- is a step-wise process that features two state transformations: The first state transformation involves accessing the felt sense: The therapist urges the patient to go to the body, and find the bodily experience associated with the problem --*the felt sense*. The patient then seeks a verbal expression that does justice to that felt sense, a *handle* that captures the personal quality of the felt sense. The joining of the experience with the label that accurately describes it --an invariably idiosyncratic and highly personal term-- for the felt sense leads to the next state transformation. The new state is heralded by the experience of *body shift*, a relaxation, a letting go, a release of tension. The body shift, the state transformation associated with somatic focusing, is always in the direction of

well-being. The goal is to heal through "engaging the bodily process that should have happened, rather than merely reliving what happened" (Gendlin).

Again, we have by now the familiar components of the intrinsic tendency of adaptive processes to move toward healing and positive changes, and the association of such processes with positive affective markers.

> "The irony is that the life-threatening events prehistoric people routinely faced molded our modern nervous system to respond powerfully and fully when we perceive our survival threatened. To this day, when we exercise this natural capacity, we feel exhilarated and alive, powerful, expanded, full of energy and ready to take on any challenge. Being threatened engages our deepest resources and allows us to experience our fullest potential as human beings. In turn, our emotional and physical well-being is enhanced" (Levine, 1997, pp. 42-43).

Thus, here too, by focusing on the sensations of the body, and doing so with no agenda, yet another positive transformational process is activated. We access a bodily core state marked by openness and relaxation. Even if the problem remains the body is now in an optimal state where its capacities, its adaptive action tendencies if you will, are maximally engaged. Furthermore, the very process of change itself, and not only its outcome, feels good. Each session, all therapists should heed Eugene Gendlin's radical point, all the more profound for its simplicity: "Nothing that feels bad is ever the last step." (Gendlin, 1981, p. 25-26.)

Affective neuroscience provides further support. By having a process where there is an alternation of body-focused somatic experiencing (subcortical, right-brain), with reflection upon the somatic experience (cortical, left brain), there is the opportunity for the integration of bilateral sources of processing, deemed essential to optimal health (Siegel, 1999). It is the process of bilateral stimulation and the harnessing of the processing potential and abilities of both sides of the brain (as well as of lower and higher brain functions) which is thought to be responsible for the healing mechanisms of EMDR specifically (Shapiro, 1995), and of healthy functioning in general.

Conclusion

In normal, optimal development, deep emotional experiences --particularly when occurring in the presence of a supportive, affect-facilitating other-- serve adaptive aims and are fundamental to the individual's optimal functioning and well-being. They become associated with feeling good. To authentically and deeply express oneself feels good. To feel emotionally connected with someone feels good. To feel understood feels good and, in turn, to be understanding or generous toward someone else, who welcomes receiving it and is touched by it, also feels good. It turns out that expressing painful feelings to a receptive partner also feels good. Positive affective states, are markers for processes and experiences that are highly adaptive for the individual; these positive affective

states are the way Mother Nature ensures that we pay attention to and keep engaging in psychic activities which prove to be maximally beneficial to the development, growth and expansion of the individual.

In pathogenic environments, these very processes, instead of bringing psychic gains, bring aversive results: Expressing oneself meets with disdain or criticism. The desire for contact meets with rejection or withdrawal. The offering of love is met with indifference or incomprehension. The expression of distress meets with blankness and denial. Thus, what should feel good ends up feeling bad. To emotionally survive, the child develops defense mechanisms that are adaptive to the prevailing conditions. A secondary security is achieved through the defensive exclusion of the very psychic activities characteristic of optimal psychic health (Bowlby, 1988): the patient learns to deny, constrict, avoid, numb or disavow those emotional experiences that wreak havoc. The notion of defense and its psychic consequences is key in the psychodynamic of psychopathogenesis. . It underlies the process of pathology in which the natural order, so to speak, is reversed: feeling good, safe, and secure, becomes associated with not feeling, and feeling bad becomes associated with emotional experience. The defensive exclusion from experience of so many adaptive psychic functions leaves the individual with terribly reduced resources to face the challenges of the world at large.

Treatment aims to reverse and restore the psychic equation and help the patient rediscover that what is good for you, i.e., read adaptive, growth-

promoting and facilitating of optimal functioning and emotional well-being, actually feels good. Like Gendlin says, nothing that feels bad is ever the last step. Through undoing pathogenic processes (based on the chronic reliance on defenses against experiencing and their consequences) and restoring the natural healing and self-reparative tendencies of the individual (rooted in the experience of core affective phenomena), the ultimate goal of the therapy is to change the structure of the patient's experience of what feels good. *Thus it is our hope to change the nature of what feels good by restoring the association of states of safety and well-being with full experiential engagement in adaptive emotional processes. In this way, the individual has access to the deep wells of energy, healing, vitality and creativity contained within them*

With an understanding reflecting the integration of the psychodynamic, relational and experiential therapeutic traditions, the therapist's activities are rooted in the moment-to-moment tracking of the patient's experiential access to these sources of transformation: through bypassing defenses (psychodynamic contribution) and enhancing embodied visceral experience (experiential contribution) in the context of an affirming affect-facilitating relationship (relational component), the AEDP therapist seeks to harness the transformations arising (a) from the experiencing of core affect, (b) from forming and being in a dyadic relationship where the mutual coordination of affective states yields safety and affective resonance, and (c) from somatic focusing, with its shifting the patient's focus from being in-the-head to being in-the-body, and reap their

benefits to help patients heal and increasingly approach, and thrive, becoming who they are.

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